ICER of rituximab maintenance vs. observation alone is, therefore, estimated to be R$32,236 per QALY gained. The ICER of rituximab maintenance was sensitive to the duration of treatment benefit, discount rate and drug cost. **CONCLUSION:** In patients responding to induction therapy, rituximab maintenance therapy improves overall survival and progression-free survival compared with observation alone. Results suggest that maintenance therapy with rituximab is a cost-effective intervention for the management of patients with follicular lymphoma in the Brazilian Private Healthcare System.

PCN50

COST SHIFTING EFFECT IN DRG BASED ANTI-CANCER THERAPIES IN HUNGARY

Jozsa G
University of West Hungary, Sopron, Hungary

OBJECTIVES: The goal of research was to investigate the cost of DRG based anti-cancer chemotherapies. Costs for investigated chemotherapies have been allocated to oncology centers from the budget of National Heath Fund Administration, based on DRG-reimbursement. **METHODS:** Cost analysis of chemotherapy protocols has been conducted, from the perspective of National Heath Fund Administration, focusing on cost of medication, hospitalisation and the total expenditure of protocols. **RESULTS:** The standard process of protocol-expenditure calculation has been identified. The drug related cost has been based on the ex-factory prices of medicines. Expenditures of hospitalisation have been calculated on the days of total length of drug administration and not on term of hospitalisation. Chemotherapies, containing per os anti-cancer medication have been found over-charged. The cost ratio of oral drug and protocol expenses has been found lower than the average of oncology protocols, from 1,75 to 26.9%. Consequetly, the cost of hospitalisaton has been over-represented in these protocolls, although these treatments have reqired less hospitalisation. Using per os chemotherapy protocols has resulted idle capacity in utilization of protocol-expenditures. **CONCLUSION:** The cost of hospitalisation based on "days of treatment" hasn't reflected correctly the occurrent expenses. Per os chemotherapies alone should have been reimbursed as outpatient care and not involved into DRG based hospital care. The cost of protocols, containing per os and i.v. compounds in combination should have been calculated on a real-cost basis, considering the days of hospitalisation.

CANCER—Health Care Use & Policy Studies

PCN51

COMPARING THE BURDEN OF CANCER AND OTHER DISEASES WITH THE ECONOMIC RESOURCES ALLOCATED TO THOSE DISEASES: A SOUTH AFRICAN PERSPECTIVE

Stander MP[1], Harmse WJJ[2], Cooke RA[2], Marais CA[2]
[1]heXor—Health Exonometrix & Outcomes Research, Johannesburg, Gauteng, South Africa, [2]heXor, Gauteng, Gauteng, South Africa

OBJECTIVES: To calculate the burden of cancer in the private and public healthc care sector, compare it to the health care resources consumed, and to other disease areas. Ultimately we seek to understand whether scarce health care resource allocation is optimally distributed between different diseases. **METHODS:** We first attempted to calculate the burden of cancer for South Africa using Statistics SA, South African death registry and the National Cancer Registry data. Using different data sets we then differentiated the data in order to estimate the public and private sector burden of cancer. By using the latest South African National Health Accounts and medical insurance data, we then calculated the direct monetary health care resources for cancer and other diseases. Lastly we attempted to calculate the indirect costs associated with cancer and other diseases using the human capital methodology. We were able to compare burden of cancer, cardiovascular disease, diabetes, HIV/AIDS, injuries, mental disease, respiratory disease and all other diseases to the direct monetary health care resources as well as the indirect costs associated with disease. **RESULTS:** HIV/AIDS and injuries contributed 30.9% and 14.3% to the burden of disease in South Africa while cancer was 3.1%. When comparing the direct health care cost as a percentage of total health care spending to the cancer DALY as a percentage of total DALY, the ratio was 1.07. This indicates that, from a direct health care cost perspective, direct health care cost consumption was proportionate to the burden. However, when comparing direct health care cost percentage to indirect costs percentage, the ratio for cancer is 0.36. Similar results were seen in the public and private sector. **CONCLUSION:** From a societal perspective, it appears that too little resources are allocated to cancer and some other chronic diseases in South Africa.

PCN52

GAP BETWEEN TREATMENT COST OF AND MORTALITY DUE TO CERVICAL CANCER IN HUNGARY

Boncz I[1], Péntek M[2], Ágoston I[1], Betlehem J[1], Karpati K[3], Brodszky V[3], Gulácsi L[3], Sebestyén A[4]
[1]University of Pécs, Pécs, Hungary, [2]Flor Ferenc County Hospital, Kistarcsa, Hungary, [3]Corvinus University of Budapest, Budapest, Hungary, [4]National Health Insurance Fund Administration, Pécs, Hungary

OBJECTIVES: The aim of this study is to compare the distribution of health insurance treatment cost of and mortality due to cervical cancer according to age-groups. **METHODS:** Data derive from the database of the National Health Insurance Fund Administration (OEP) containing routinely collected financial data. The study includes all the women who received outpatient and/or inpatient care treatment in 2001 financed from public resources of OEP. Number of deaths due to cervical cancer is from the Central Statistical Office database. We compared the annual out- and inpatient care treatment cost and the annual number of deaths according to age groups. **RESULTS:** The cost distribution of out- and inpatient care treatment cost of cervical cancer was the following (outp./inp.): 0–24 years: 0.2%/0.2%; 25–44 years: 33.2%/35.8%; 45–64 years: 47.2%/47.3%; 65–74 years: 12.9%/13.2%; 75 and over: 6.5%/3.6%. The distribution of deaths due to cervical cancer was the following: 0–24 years: 0.0%; 25–44 years: 16.3%; 45–64 years: 41.0%; 65–74 years: 21.7%; 75 and over: 21.0%. Summarizing these numbers, women aged 0–64 years accounts for 57.3% of all deaths due to cervical cancer but they received 80.6% and 83.3% of treatment cost of in- and outpatient care. While women aged 65 or over accounts for 42.7% of deaths and consumed only 19.4% and 16.7% of of treatment cost of in- and outpatient care. **CONCLUSION:** Women in younger age groups received more treatment cost than its mortality would predict, while women in older age groups received less treatment cost of out- and inpatient care. There is a shift between the distribution of treatment cost of and deaths due to cervical cancer in favor of younger age-groups.